BEFORE THE ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD

IN THE MATTER OF: MONIKA KNOBLICH, DVM HOLDER OF LICENSE NO. 6358 FOR THE PRACTICE OF VETERINARY MEDICINE IN THE STATE OF ARIZONA, RESPONDENT.	CASE NO.: 20-03 FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER (AMENDED)

In accordance with the April 15, 2020 action of the Arizona State Veterinary Medical Examining Board ("Board") granting, in part, Monica Knoblich, D.V.M.'s Motion for Review and Rehearing, the following Findings of Fact, Conclusions of Law and Order (Amended) is issued:

FINDINGS OF FACT

1. Respondent is the holder of License No. 6358 issued on January 15, 2014, and is therefore authorized to practice the profession of veterinary medicine in the State of Arizona.

2. On July 12, 2019, Complainant reported that she had scheduled an appointment for her dog, "Rio," a 5-year-old male Doberman Pinscher, with Respondent for that evening due to the dog's appetite declining, possible labored breathing and possible distended abdomen. That afternoon, the dog ate a full meal and since the dog was known to be a finicky eater, Complainant canceled the appointment with Respondent.

3. On July 15, 2019, Complainant rescheduled an appointment with Respondent due to the same issues except the dog also appeared to be

lethargic. Complainant could not get the dog to eat any food and she was concerned with the dog's breathing and possible distended abdomen.

4. That morning the dog was presented to Respondent's premises. Technical staff took the dog into the treatment area to draw blood then brought the dog back to Complainant to wait for Respondent to arrive. When Respondent arrived, she examined the dog; weight = 103.6 pounds, a temperature = 99.8 degrees, a pulse rate = 160bpm and a respiration rate = labored – BCS 5.5/9, QAR, depressed. Respondent noted the dog appeared stressed, had pink tacky mucous membranes, was dyspneic with abdominal component, had a distended abdomen – no appreciable masses, erratic, abnormal rhythm – heart murmur 2 – 3/6 -- left sided, pulse deficits and raspy lungs ventrally. Complainant advised that the dog was currently taking Clindamycin 275mg twice a day for 2 days.

5. Blood work revealed some abnormalities and radiographs showed gas in the intestines, no evidence of GDV, enlarged cardiac silhouette, and increased opacity in the lungs.

6. EKG showed an abnormal rhythm. The dog became cyanotic during radiographs and became increasingly weak and dyspneic with EKG.

7. Respondent documented that she was highly suspicious of atrial fibrillation and wanted to rule-out other causes of cardiac arrhythmia and needed to rule-out Valley Fever. She wrote in the record that she gave the Complainant a guarded prognosis and strongly urged referral to an emergency facility for overnight care – Complainant declined. Respondent stated that she advised Complainant that she could treat for atrial fibrillation but could not guarantee appropriateness of the treatment but felt the dog would die without treatment.

8. However, according to Complainant, Respondent advised that she did not see anything concerning on the dog's blood work and was not concerned about bloating however there was gas in his intestines. She further explained that the lungs were not great, but not bad either. Respondent offered to send the radiographs to be read by a radiologist but was confident in what she saw; due to Respondent's confidence, Complainant declined sending the radiographs to a radiologist – heartworm test was also declined.

9. Respondent then discussed the dog's EKG. According to Complainant, Respondent explained that she was not a cardiologist but believed the dog had atrial fibrillation. There was no consistent rhythm when she listened to the dog's heart, it was all over the place; Respondent also heard a heart murmur. Complainant stated that Respondent said she could take the dog to a cardiologist for an ultrasound of the heart to confirm the diagnosis, but there was no sense of urgency. However, Respondent stated that she advised that the dog needed to be treated for atrial fibrillation and needed to be treated for life or the dog would die.

10. Complainant asked about testing for Valley Fever and Respondent agreed to test but her suspicion was low. When asked about treating for Valley Fever, Respondent stated she would not treat without a positive result. Respondent claimed she repeatedly stated that the dog needed be treated for atrial fibrillation and would die without treatment. Respondent stated that she explained to Complainant that the dog could get worse before he got better, but to expect drastic improvement in 24 hours after medicating the dog. The dog was discharged with the following:

a. Atenolol 25mg, 120 tablets; 2 tablets orally twice a day;

b. Lasix 20mg, 120 tablets; 1 tablet orally twice a day;

c. Vetmedin 10mg, 21 tablets; 1.5 tablets orally twice a day;

d. Amoxi 500mg, 56 tablets; 2 tablets orally twice a day;

e. Meloxicam 7.5mg, 30 tablets; ½ tablet orally once a day; and

f. Rx submitted for compounding (?) – Diltiazem 90mg, 3 times a day for life (not in medical record).

11. According to Complainant, Respondent administered the first dose of the medications in the office and she was supposed to pick up Diltiazem at the pharmacy and administer the first dose at home.

12. The dog proceeded to become weaker throughout the evening and was resistant to get up or move around. Complainant administered the evening doses of medications to the dog and assisted him to his dog bed. The dog passed away later that evening.

13. The following day Complainant contacted Respondent's premises and requested to speak to Respondent; Complainant also requested a copy of the dog's medical record at that time. No return call from Respondent that day.

14. On July 17, 2019, Complainant went to Respondent's premises to pick up the medical records and was only supplied with the blood results and EKG strips. She was advised that the Valley Fever results were not back yet. Later that evening Respondent returned Complainant's call; Complainant stated that due to her line of questioning, Respondent became angry, raised her voice several times and eventually hung up on Complainant. Respondent denies this allegation and stated that Complainant ended the conversation.

15. There were many discrepancies between the two narratives with respect to what was said in the phone conversation after the dog died as well as what actually occurred during the appointment.

16. Complainant requested the dog's medical records and was told by Respondent that she could have the test results but she was not getting her notes, as she was not entitled to them. Complainant did not receive a copy of the dog's medical records or radiographs. At the time of the Board's Informal Interview of the matter, Complainant had still not received the records.

CONCLUSIONS OF LAW

17. The Arizona State Veterinary Medical Examining Board has jurisdiction over this matter pursuant to A.R.S. § 32-2201, et seq.

18. The conduct and circumstances described in the Findings of Fact above, constitutes a violation of **A.R.S. § 32-2232 (12)** as it relates to **A.A.C. R3-11-501 (1)** for failure to provide professionally acceptable procedures for not stressing the need for emergency care, nor documenting on the discharge instructions what signs and symptoms to watch for and where to obtain emergency care.

19. The conduct and circumstances described in the Findings of Fact above, constitutes a violation of **A.R.S. § 32-2232 (12)** as it relates to **A.A.C. R3-11-501 (8)** failure to provide records or copies of records, including copies of radiographs, to Complainant within 10 days from the date of request or sooner if the animal's medical condition requires.

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law it is **ORDERED** that Respondent's License, No. 6358 be placed on **PROBATION** for a period of one (1) year, subject to the following terms and conditions that shall be completed within the Probationary period. These requirements include six (6) total hours of continuing education (CE) detailed below:

1. **IT IS ORDERED THAT** Respondent shall provide written proof satisfactory to the Board that she has completed three (3) hours of continuing education (CE); hours earned in compliance with this order shall not be used for licensure renewal. Respondent shall satisfy these three (3) hours by attending CE in the area of emergency medicine. Respondent shall submit written verification of attendance to the Board for approval.

2. **IT IS ORDERED THAT** Respondent shall provide written proof satisfactory to the Board that she has completed three (3) hours of continuing education (CE); hours earned in compliance with this order shall not be used for licensure renewal. Respondent shall satisfy these three (3) hours by attending CE in the area of communication. Respondent shall submit written verification of attendance to the Board for approval.

3. **IT IS FURTHER ORDERED THAT** Respondent shall pay a civil penalty of seven hundred fifty dollars ($750) on or before the end of the Probation period. Civil penalty shall be made payable to the Arizona State Veterinary Medical Examining Board and is to be paid by **cashier's check** or **money order**.

4. **All continuing education to be completed for this Order shall be pre-approved by the Board.** Respondent shall submit to the Board a written outline regarding how she plans to satisfy the requirements in paragraphs 1 and 2 for its approval within sixty (60) days of the effective date of this Order. The outline

shall include **CE course details** including, **name, provider, date(s), hours of CE** to be earned, and a **brief course summary**.

5. Respondent shall obey all federal, state and local laws/rules governing the practice of veterinary medicine in this state.

6. Respondent shall bear all costs of complying with this Order.

7. This Order is conclusive evidence of the matters described and may be considered by the Board in determining an appropriate sanction in the event a subsequent violation occurs. In the event Respondent violates any term of this Order, the Board may, after opportunity for Informal Interview or Formal Hearing, take any other appropriate disciplinary action authorized by law, including suspension or revocation of Respondent's license.

Dated this 11th day of May, 2020.

Arizona State Veterinary Medical Examining Board
Jim Loughead
Chairman

By: Victoria Whitmore
Victoria Whitmore, Executive Director

Original of the foregoing filed this 11th day of May, 2020 with the:

Arizona State Veterinary
Medical Examining Board
1740 W. Adams St., Ste. 4600

Phoenix, Arizona 85007

Copy of the foregoing sent by certified, return receipt mail this 11th day of May, 2020 to:

Monika Knoblich, DVM
Address on file
Respondent

Copy of the foregoing sent by regular mail this 11th day of May, 2020 to:

David Stoll, Esq.
Beaugureau, Hancock, Stoll and Schwartz, PC
302 E. Coronado Rd
Phoenix, Arizona 85004

By: V. Whitmore
Board Staff

BEFORE THE ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD

IN THE MATTER OF: **MONIKA KNOBLICH, DVM** HOLDER OF LICENSE NO. 6358 FOR THE PRACTICE OF VETERINARY MEDICINE IN THE STATE OF ARIZONA, **RESPONDENT.**	**CASE NO.: 20-03** ORDER GRANTING REVIEW

At its public meeting on April 15, 2020, the Arizona State Veterinary Medical Examining Board ("Board") considered Monika Knoblich, D.V.M.'s ("Respondent") Motion for Rehearing or Review requesting modification of the Board's Findings of Fact, Conclusions of Law and Order, previously issued by the Board in the above-referenced matter. After considering all of Respondent's arguments and the evidence in the record, the Board voted to grant Respondent's Motion for Rehearing or Review, in part, to review the number of continuing education hours and the amount of the civil penalty ordered. After its review, the Board voted to modify the amount of the continuing education hours to accurately reflect the continuing education hours previously voted on by the Board-which were 3 hours in continuing education in communication and 3 hours in emergency medicine. The Board did not modify the $750.00 civil penalty previously ordered.

RIGHT TO APPEAL TO SUPERIOR COURT

Respondent is hereby notified that she has exhausted her administrative remedies. Respondent is advised that an appeal to Superior Court in Maricopa

County may be taken from this decision pursuant to title 12, chapter 7, and article 6 of the Arizona Revised Statutes.

Dated this 11th day of May, 2020.

Arizona State Veterinary Medical Examining Board
Jim Loughead
Chairman

By: Victoria Whitmore
Victoria Whitmore, Executive Director

Original of the foregoing filed this 11th day of May, 2020 with the:

Arizona State Veterinary
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Address on file
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David Stoll, Esq.
Beaugureau, Hancock, Stoll and Schwartz, PC
302 E. Coronado Rd
Phoenix, Arizona 85004

By: _____
Board Staff

BEAUGUREAU, HANCOCK,
STOLL & SCHWARTZ, P.C.
302 East Coronado Road
Phoenix, Arizona 85004
(602) 956-4438

David L. Stoll (#010728) dstoll@bhsslaw.com
Attorneys for Monika Knoblich, D.V.M.

BEFORE THE ARIZONA STATE

VETERINARY MEDICAL EXAMINING BOARD

In the Matter of: Monika Knoblich, D.V.M. and for the Practice of Veterinary Medicine in the State of Arizona	**MOTION FOR REHEARING OR REVIEW** Complaint No. 20-03

Pursuant to A.A.C. R3-11-904(C), A.R.S. §32-2234(H) and A.R.S. §41-1092.09, Respondent Monika Knoblich, D.V.M., by and through her attorneys, Beaugureau, Hancock, Stoll & Schwartz, hereby files this Motion for Rehearing or Review of the Board's March 2, 2020 Findings of Fact, Conclusions of Law, and Order (hereinafter the "Order"). Specifically, Respondent contends that one of the two violations in the Order is not supported by the evidence and is contrary to law and further that the Order is inconsistent with the action actually taken by the Board during its February 19, 2020 meeting and contains an excessive penalty based upon mistake, misconduct or irregularities in the proceedings.

I. FACTUAL SUMMARY

1. The Complaint in this case was filed on July 29, 2019.

2. On January 15, 2020 and February 19, 2020, the Arizona State Veterinary Medical Examining Board (the "Board") conducted an Informal Interview pursuant to A.R.S. §32-2234(A).

3. During the Informal Interview, the Board found two violations.

4. The first violation, under A.R.S. §32-2232(12) as it relates to R3-11-501(1), was "for an alleged failure to provide professionally acceptable procedures for not stressing the need for emergency care", and for not documenting on discharge instructions what signs and symptoms to watch for and where to obtain emergency care. (Order page 5, line 23 to page 6, line 2).

5. The second violation, under A.R.S. §32-2232(12) as it relates to R3-11-501(8), was for an alleged failure to provide Complainant records or copies of records in a timely manner.

6. Following the February 16, 2020 Informal Interview, the Board issued the Order, which will place Respondent's license on probation for one (1) year subject to the following:

A) Respondent is to complete 4 (four) hours of continuing education in the area of emergency medicine;

B) Respondent is to complete 4 (four) hours of continuing education in the area of communication; and

C) Respondent is to pay a civil penalty of seven hundred fifty dollars ($750.00).

II. LEGAL ARGUMENT

A.A.C. R3-11-904(C) provides that the Board may grant a rehearing or review for various reasons including when the findings of fact or decisions are the result of an irregularity (subsection 1), misconduct (subsection 2) or accident (subsection 3), when the penalties are

excessive (subsection 5) or when the decisions are not supported by the evidence or are contrary to law (subsection 7).

Respondent asserts that a review and rehearing are warranted in this case because the evidence does not support the conclusions that a) Respondent failed to offer and stress the need for emergency care and b) that Respondent failed to advise the Complainant where to obtain emergency care. In addition, the Order includes a violation that fails, as a matter of law, to comport with the Arizona Practice Act as it relates to documenting discharge instructions and contains an excessive penalty that was not voted on or agreed to by the Board.

A. THE VIOLATION OF A.R.S. §32-2232(12) AS IT RELATES TO A.A.C. R3-11-501 IS NOT SUPPORTED BY THE EVIDENCE AND IS CONTRARY TO LAW

Stressing Need for Emergency Care

The primary factual basis for the violation of A.A.C. R3-11-501 is Respondent's alleged failure to stress "the need for emergency care". (Order, page 5, line 25 to page 6, line 1). This is not supported anywhere in the record. To the contrary, the only finding of fact in the Order relating to the need for emergency care is set forth on page 3, paragraph 7 and reads as follows:

> "She (Respondent) wrote in the record that she gave the Complainant a guarded prognosis and **strongly urged referral to an emergency facility** for overnight care-Complainant declined." (Order, page 3, lines 8-10 emphasis added).

This finding of fact was consistent with Respondent's uncontroverted testimony during the Informal Interview that she strongly stressed referral to an emergency facility.

"Strongly urging" a referral to an emergency facility is the same thing as stressing the need for emergency care. Further, nowhere in the Findings of Fact is evidence cited to contradict that Respondent strongly urged the need for emergency care and therefore there is no factual basis to support this violation.

Also, the All Creatures medical record for the date of the subject visit, July 15, 2019, contains the following entry "Gave owner a very guarded px and **strongly urged referral** to ER for overnight ICU care- owner declined." In the face of this documentary evidence, the aforementioned Finding of Fact number 7, and the absence of any controverting evidence, the Board somehow issued a violation for Respondent failing to stress the need for emergency care. For the it to come to that conclusion, the Board had to find that "strongly urging" is something different than "stressing". That strains credulity.

Alleged Failure to Document Where to Obtain Emergency Care

The second factual basis for the violation of A.A.C. R3-11-501 is Respondent's alleged failure to advise the Complainant "where to obtain emergency care". (Order, page 6, line 2). In reaching this conclusion, the Board completely ignored the July 15, 2019 Invoice that was given to Respondent at the time of discharge because the bottom of the invoice contains the following language:

> After-hours/**emergency services** can be obtained in Tucson at: Veterinary Specialty Center of Tucson 520-795-9555, 4909 N La Canada 85074 or Southern Arizona Veterinary Specialty & Emergency Center 520-888-3177; 7474 E Broadway Blvd, 85710 (July 15, 2019 Invoice, emphasis added)

Clearly, Respondent advised the Complainant, in writing, of **two** separate facilities where she could obtain emergency care for her pet. This Invoice was in the medical records provided to the Board by Respondent in her Response and were apparently mistakenly overlooked by the Board. In light of the foregoing, there is clear evidence that Complainant was advised where to get emergency care and therefore no basis to support the violation cited in the Order for failing to advise Complainant where to obtain emergency care.

Discharge Instructions Deficiencies

Finally, the cited violation of A.R.S. §32-2232(12) as it relates to R3-11-501(8) and the perceived deficiencies in documenting the discharge instructions as to what signs and symptoms to watch for is contrary to Arizona law. R3-11-502(E) governs the documentation of discharge instructions and provides as follows:

> E. Before a **surgical patient** or **hospitalized animal** is discharged, a veterinarian shall ensure that the animal owner is provided with instructions detailing care of the animal after discharge and documents in the medical record that verbal or written care instructions were provided. (Emphasis added)

Nowhere in the Findings of Fact is there a finding that the subject dog, "Rio", was either a surgical patient or a hospitalized animal. That is because the dog was neither. The subject veterinary services were provided during routine office visits and while the Respondent testified unequivocally that verbal discharge instructions were given, she was not required to document the instructions in the medical record because R3-11-502(E) only requires such documentation of discharge instructions in cases involving "a surgical patient or hospitalized animal".

B. THE ORDER CONTAINS PENTALIES IN EXCESS OF THOSE VOTED UPON AND DECIDED BY THE BOARD

The granting of this Motion for Review and Reconsideration is clearly compelled by the fact that the Order does not even comport with the action taken by the Board during its February 19, 2020 Informal Interview. As set forth in the minutes for the February 19, 2020 Informal Interview that are attached as Exhibit "A", a motion was made by Dr. Jaynes and seconded by Dr. Heinrich to issue Respondent an Order that included **six (6) hours of continuing education,** 3 hours in emergency medicine and 3 hours in communication. That motion passed unanimously.

Despite the action taken by the Board on February 19, 2020, the Order includes a penalty for eight (8) hours of continuing education, 4 hours in emergency medicine and 4 hours in communication. In other words, the Board has issued an Order that contains penalties that exceed those authorized and approved of during the Informal Interview. As a result, the Order has materially and adversely affected the Respondent's rights for purposes of R3-11-904. Presumably the unauthorized and excessive penalty is the result of a mistake, an irregularity in the proceedings, misconduct or accident under R3-11-904(C) and requires that the Board grant this Motion to correct their mistake.

III. CONCLUSION

Again, the fact that the Order does not comport with the action taken by the Board on February 19, 2020 alone compels a granting of this motion. Further, the Board's findings that Respondent failed to follow professionally acceptable procedures with respect to stressing the need for emergency care and failing to provide the name of an emergency room facility are clearly not supported by the evidence. There is therefore no factual basis for the Board to have found a violation of A.R.S. §32-2232(12) as it relates to A.A.C. R3-11-501.

In light of the foregoing, Respondent requests that the Board reconsider its March 2, 2020 Order, and issue a new order which contains only the violation relating to §32-2232(12) as it relates to A.A.C. R3-11-501(8) for failure to provide records or copies of records within 10 days from the date of the request. Similarly, the new order should not include a requirement that Respondent complete eight (8), six (6) or any hours of additional continuing education and the civil penalty should be reduced to an amount commensurate with a violation for failing to provide records in a timely manner; namely, $250.00. Alternatively, Respondent requests that the Board set this matter for a rehearing so that the circumstances surrounding the excessive

penalties, referral for emergency care and discharge instructions can be more thoroughly evaluated by the Board before rendering a final decision in this matter.

DATED this 31st day of March, 2020.

BEAUGUREAU, HANCOCK
STOLL & SCHWARTZ, P.C.

By: _____
David L. Stoll
302 East Coronado Road
Phoenix, Arizona 85004
Attorneys for Monika Knoblich, D.V.M.

ORIGINAL AND ONE (1) COPY of the foregoing mailed and e-mailed this 31st day of March, 2020, to:

Arizona State Veterinary Medical Examining Board
1740 West Adams Street, Suite 4600
Phoenix, Arizona 85007

_____
Lori Curry

EXHIBIT "A"

modify the Investigative Committee's first proposed Conclusions of Law from ARS § 32-2232 (12) as it relates to AAC R3-11-501 (1) with respect to current professional scientific knowledge to ARS § 32-2232 (11) gross negligence. Roll call: Ms. Creager, aye; Ms. Soloman, aye; Dr. Wright, aye; Mr. Loughead, aye; Dr. Heinrich, aye; and Dr. Jaynes, aye. Motion passed unanimously.

After further discussion and consideration, a motion was made by Dr. Jaynes and seconded by Dr. Heinrich to offer Dr. Knoblich a Consent Agreement to include a period of **Probation for 1-year** to obtain **eight (8) hours of continuing education**, in addition to the statutory requirements to maintain licensure. Those eight (8) hours are to include:

- 4 hours in medical record keeping; and
- 4 hours in antibiotic usage.

The Consent Agreement shall also include a **civil penalty of $1000** to be paid on or before the end of the Probationary period and **reimbursement of fees** paid by Ms. Tulk collected by Dr. Knoblich with respect to the treatment of the dog from August 1, 2019 through August 5, 2019. Roll call: Ms. Creager, aye; Ms. Soloman, aye; Dr. Wright, aye; Mr. Loughead, aye; Dr. Heinrich, aye; and Dr. Jaynes, aye. Motion passed unanimously.

11. 20-64, In Re: Paul Pullen, DVM
Dr. Pullen was present and made statements. After discussion and consideration, a motion was made by Ms. Creager and seconded by Dr. Heinrich to **dismiss** this issue with no violation. Motion passed unanimously.

III. INFORMAL INTERVIEWS - BOARD DELIBERATION AND ACTION

1. 20-03: In Re: Monika Knoblich, DVM – Continuance of Informal Interview of January 15, 2020, for the purpose of receiving additional information and reviewing and possible action to approve proposed Findings of Fact, Conclusions of Law and adopting an Order.
After discussion and consideration, a motion was made by Dr. Jaynes and seconded by Dr. Heinrich to approve the proposed Findings of Fact and Conclusions of Law as drafted. Motion passed unanimously.

After further discussion and consideration, a motion was made by Dr. Jaynes and seconded by Dr. Heinrich to issue Dr. Knoblich an Order to include a period of **Probation for 1-year** to obtain **six (6) hours of continuing education**, in addition to the statutory requirements to maintain licensure. Those six (6) hours are to include:

- 3 hours in emergency medicine;
- 3 hours in communication.

The Order shall also include a **civil penalty of $750** due on or before the end of the Probationary period. Roll call: Ms. Creager, aye; Ms. Soloman, aye; Dr. Wright, aye; Mr. Loughead, aye; Dr. Heinrich, aye; and Dr. Jaynes, aye. Motion passed unanimously.

IV. ADMINISTRATIVE REVIEW OF PREVIOUS ACTIONS

1. 19-83: In Re: Gurjit Sandhu, DVM. Board may review, discuss, and take action on Continuing Education plan submitted in compliance with Board Order.

BEFORE THE ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD

IN THE MATTER OF: **MONIKA KNOBLICH, DVM** Holder of License No. 6358 For the practice of Veterinary Medicine in the State of Arizona, **Respondent.**	**Case No.: 20-03** **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER**

On January 15, 2020 and February 19, 2020, the Arizona State Veterinary Medical Examining Board conducted an Informal Interview regarding Monika Knoblich, DVM ("Respondent"). The proceedings in this matter are governed by A.R.S. § 32-2234 (A). Respondent was advised of her right to legal counsel by letter, appeared, and participated telephonically in the Informal Interview with counsel, David Stoll. The Board reviewed all documents submitted regarding this matter, took testimony from Respondent, and proceeded as is permitted by A.R.S. § 32-2234 (A).

Following the Informal Interview and the Board's discussion of the information and documents submitted, the Board determined that Respondent's conduct constituted unprofessional conduct pursuant A.R.S. § 32-2232 (12) as it relates to A.A.C. R3-11-501 (1) failure to provided professionally acceptable procedures and A.A.C. R3-11-501 (8) failure to provide copies of medical records to an animal owner. After considering all of the information and testimony, the Board issues the following Findings of Fact, Conclusions of Law and Order, ("Order").

FINDINGS OF FACT

1. Respondent is the holder of License No. 6358 issued on January 15, 2014, and is therefore authorized to practice the profession of veterinary medicine in the State of Arizona.

2. On July 12, 2019, Complainant reported that she had scheduled an appointment for her dog, "Rio," a 5-year-old male Doberman Pinscher, with Respondent for that evening due to the dog's appetite declining, possible labored breathing and possible distended abdomen. That afternoon, the dog ate a full meal and since the dog was known to be a finicky eater, Complainant canceled the appointment with Respondent.

3. On July 15, 2019, Complainant rescheduled an appointment with Respondent due to the same issues except the dog also appeared to be lethargic. Complainant could not get the dog to eat any food and she was concerned with the dog's breathing and possible distended abdomen.

4. That morning the dog was presented to Respondent's premises. Technical staff took the dog into the treatment area to draw blood then brought the dog back to Complainant to wait for Respondent to arrive. When Respondent arrived she examined the dog; weight = 103.6 pounds, a temperature = 99.8 degrees, a pulse rate = 160bpm and a respiration rate = labored – BCS 5.5/9, QAR, depressed. Respondent noted the dog appeared stressed, had pink tacky mucous membranes, was dyspneic with abdominal component, had a distended abdomen – no appreciable masses, erratic, abnormal rhythm – heart murmur 2 – 3/6 -- left sided, pulse deficits and raspy lungs ventrally. Complainant advised that the dog was currently taking Clindamycin 275mg twice a day for 2 days.

5. Blood work revealed some abnormalities and radiographs showed gas in the intestines, no evidence of GDV, enlarged cardiac silhouette, and increased opacity in the lungs.

6. EKG showed an abnormal rhythm. The dog became cyanotic during radiographs and became increasingly weak and dyspneic with EKG.

7. Respondent documented that she was highly suspicious of atrial fibrillation and wanted to rule-out other causes of cardiac arrhythmia and needed to rule-out Valley Fever. She wrote in the record that she gave the Complainant a guarded prognosis and strongly urged referral to an emergency facility for overnight care – Complainant declined. Respondent stated that she advised Complainant that she could treat for atrial fibrillation but could not guarantee appropriateness of the treatment but felt the dog would die without treatment.

8. However, according to Complainant, Respondent advised that she did not see anything concerning on the dog's blood work and was not concerned about bloating however there was gas in his intestines. She further explained that the lungs were not great, but not bad either. Respondent offered to send the radiographs to be read by a radiologist but was confident in what she saw; due to Respondent's confidence, Complainant declined sending the radiographs to a radiologist – heartworm test was also declined.

9. Respondent then discussed the dog's EKG. According to Complainant, Respondent explained that she was not a cardiologist but believed the dog had atrial fibrillation. There was no consistent rhythm when she listened to the dog's heart, it was all over the place; Respondent also heard a heart murmur. Complainant stated that Respondent said she could take the dog to a cardiologist for an ultrasound of the heart to confirm the diagnosis, but there

was no sense of urgency. However, Respondent stated that she advised that the dog needed to be treated for atrial fibrillation and needed to be treated for life or the dog would die.

10. Complainant asked about testing for Valley Fever and Respondent agreed to test but her suspicion was low. When asked about treating for Valley Fever, Respondent stated she would not treat without a positive result. Respondent claimed she repeatedly stated that the dog needed be treated for atrial fibrillation and would die without treatment. Respondent stated that she explained to Complainant that the dog could get worse before he got better, but to expect drastic improvement in 24 hours after medicating the dog. The dog was discharged with the following:

a. Atenolol 25mg, 120 tablets; 2 tablets orally twice a day;

b. Lasix 20mg, 120 tablets; 1 tablet orally twice a day;

c. Vetmedin 10mg, 21 tablets; 1.5 tablets orally twice a day;

d. Amoxi 500mg, 56 tablets; 2 tablets orally twice a day;

e. Meloxicam 7.5mg, 30 tablets; ½ tablet orally once a day; and

f. Rx submitted for compounding (?) – Diltiazem 90mg, 3 times a day for life (not in medical record).

11. According to Complainant, Respondent administered the first dose of the medications in the office and she was supposed to pick up Diltiazem at the pharmacy and administer the first dose at home.

12. The dog proceeded to become weaker throughout the evening and was resistant to get up or move around. Complainant administered the evening doses of medications to the dog and assisted him to his dog bed. The dog passed away later that evening.

13. The following day Complainant contacted Respondent's premises and requested to speak to Respondent; Complainant also requested a copy of the dog's medical record at that time. No return call from Respondent that day.

14. On July 17, 2019, Complainant went to Respondent's premises to pick up the medical records and was only supplied with the blood results and EKG strips. She was advised that the Valley Fever results were not back yet. Later that evening Respondent returned Complainant's call; Complainant stated that due to her line of questioning, Respondent became angry, raised her voice several times and eventually hung up on Complainant. Respondent denies this allegation and stated that Complainant ended the conversation.

15. There were many discrepancies between the two narratives with respect to what was said in the phone conversation after the dog died as well as what actually occurred during the appointment.

16. Complainant requested the dog's medical records and was told by Respondent that she could have the test results but she was not getting her notes, as she was not entitled to them. Complainant did not receive a copy of the dog's medical records or radiographs. At the time of the Board's Informal Interview of the matter, Complainant had still not received the records.

CONCLUSIONS OF LAW

17. The Arizona State Veterinary Medical Examining Board has jurisdiction over this matter pursuant to A.R.S. § 32-2201, et seq.

18. The conduct and circumstances described in the Findings of Fact above, constitutes a violation of **A.R.S. § 32-2232 (12)** as it relates to **A.A.C. R3-11-501 (1)** for failure to provide professionally acceptable procedures for not stressing

the need for emergency care, nor documenting on the discharge instructions what signs and symptoms to watch for and where to obtain emergency care.

19. The conduct and circumstances described in the Findings of Fact above, constitutes a violation of **A.R.S. § 32-2232 (12)** as it relates to **A.A.C. R3-11-501 (8)** failure to provide records or copies of records, including copies of radiographs, to Complainant within 10 days from the date of request or sooner if the animal's medical condition requires.

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law it is **ORDERED** that Respondent's License, No. 6358 be placed on **PROBATION** for a period of one (1) year, subject to the following terms and conditions that shall be completed within the Probationary period. These requirements include eight (8) total hours of continuing education (CE) detailed below:

1. **IT IS ORDERED THAT** Respondent shall provide written proof satisfactory to the Board that she has completed four (4) hours of continuing education (CE); hours earned in compliance with this order shall not be used for licensure renewal. Respondent shall satisfy these four (4) hours by attending CE in the area of emergency medicine. Respondent shall submit written verification of attendance to the Board for approval.

2. **IT IS ORDERED THAT** Respondent shall provide written proof satisfactory to the Board that she has completed four (4) hours of continuing education (CE); hours earned in compliance with this order shall not be used for licensure renewal. Respondent shall satisfy these four (4) hours by attending CE in the

area of communication. Respondent shall submit written verification of attendance to the Board for approval.

3. **IT IS FURTHER ORDERED THAT** Respondent shall pay a civil penalty of seven hundred fifty dollars ($750) on or before the end of the Probation period. Civil penalty shall be made payable to the Arizona State Veterinary Medical Examining Board and is to be paid by **cashier's check** or **money order**.

4. **All continuing education to be completed for this Order shall be pre-approved by the Board.** Respondent shall submit to the Board a written outline regarding how she plans to satisfy the requirements in paragraphs 1 and 2 for its approval within sixty (60) days of the effective date of this Order. The outline shall include **CE course details** including, **name, provider, date(s), hours of CE** to be earned, and a **brief course summary**.

5. Respondent shall obey all federal, state and local laws/rules governing the practice of veterinary medicine in this state.

6. Respondent shall bear all costs of complying with this Order.

7. This Order is conclusive evidence of the matters described and may be considered by the Board in determining an appropriate sanction in the event a subsequent violation occurs. In the event Respondent violates any term of this Order, the Board may, after opportunity for Informal Interview or Formal Hearing, take any other appropriate disciplinary action authorized by law, including suspension or revocation of Respondent's license.

REHEARING/APPEAL RIGHTS

Respondent has the right to petition for a rehearing or review of this Order. Pursuant to A.R.S. § 32-2234 (H) and § 41-1092.09 the petition must be filed with

the Board within thirty-five (35) days from the date of mailing if the Order was served via certified mail. Pursuant to A.A.C. R3-11-904 (C), the petition must set forth legally sufficient reasons for granting the rehearing or review. The filing of a petition for rehearing or review is required to preserve any rights of appeal to the Superior Court that the party may wish to pursue.

This Order shall be effective and in force upon the expiration of the above time period for filing a motion for rehearing or review with the Board. However, the timely filing of a motion for rehearing or review shall stay the enforcement of the Board's Order, unless, pursuant to A.A.C. R3-11-904 (F), the Board has expressly found good cause to believe that this Order shall be effectively immediately upon the issuance and has so stated in this Order.

Dated this 2nd day of March, 2020.

Arizona State Veterinary Medical Examining Board
Jim Loughead
Chairman

By: Victoria Whitmore
Victoria Whitmore, Executive Director

Original of the foregoing filed this 2nd day of March, 2020 with the:

Arizona State Veterinary
Medical Examining Board
1740 W. Adams St., Ste. 4600
Phoenix, Arizona 85007

Copy of the foregoing sent by certified, return receipt mail this 2nd day of March, 2020 to:

Monika Knoblich, DVM
Address on file
Respondent

Copy of the foregoing sent by regular mail this 2nd day of March, 2020 to:

David Stoll, Esq.
Beaugureau, Hancock, Stoll and Schwartz, PC
302 E. Coronado Rd
Phoenix, Arizona 85004

By: _____
Board Staff